

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

Reg. Dist. No. 00867 282

## 1. PLACE OF DEATH:

County St Marys  
 City or town Comptons Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys  
 City or town Comptons  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John Fulton Abell

## 3. (b) Social Security Number

4. Sex

Male

5. Color of race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Merna Walter Abell

7. Birth date of deceased (mo., day, yr.)

Sept 12 - 1889

6. (c) If alive, give age

57 years

8. AGE:

Years 54 Months 4 Days 16 hrs. min.

9. Birthplace

Belton Charles Maryland (Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Merchant

12. Name

Perry Abell

13. Birthplace

St Marys co

14. Maiden name

Sara Fulton

15. Birthplace

St Marys co

16. Informant

Frank Abell

Address

Mechanicsville MD

17. (Burial, cremation, or removal. Which?)

Buried

Date thereof

Jan 31 1946 (month) (day) (year)

Cemetery or crematory

St Olympos cemetery

Location

Leonardtown MD

18. Funeral director

W. C. Mathews

Address

Leonardtown MD

19. 1/30 1946 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1946 at 10:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 28 1946 to Jan 28 1946

and that I last saw him alive on Jan 28 1946

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank A. Cornelius

Address Leonardtown MD

Date signed 1/30/46

REPORT OF INVESTIGATION

STATE OF TEXAS

INVESTIGATION OF THE

RECEIVED  
FEB 1 1946  
BUREAU F.B.I.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

## CERTIFICATE OF DEATH

Reg. Dist. No. 00868 282

### 1. PLACE OF DEATH:

County St. Mary's

City or town Leonardtown, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

St. Mary's Hospital Leonardtown, Md.

How long in hospital or institution? 1-9-46 to 1-21-46

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CHAS

City or town BRYANTOWN MD  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION) ✓

2.(a) If veteran, name war \_\_\_\_\_

### 3.(a) FULL NAME

Joseph B. Burch

### 3.(b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED

6.(b) Name of husband or wife Lucy

7. Birth date of deceased (mo., day, yr.) Feb 24 - 1884

8. AGE: Years 61 Months 11 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Bryantown Md  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Mason Burch

13. Birthplace Bryantown Md

14. Maiden name Elizabeth Burch

15. Birthplace Bryantown Md

16. Informant Tom Burch son

Address Bryantown Md

17. BURIAL Date thereof 1-24-46  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory ST MARYS

Location BRYANTOWN MD

18. Funeral director Hunt & Ry. N

Address WALDORF MD

19. 1-22 19 46 M. H. Howard  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 19 46 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

Cardio-renal-Vascular disease

Due to Arterio-sclerosis &

Due to Diabetes Mellitus

Other conditions none

(Include pregnancy within 8 months of death)

Major findings of operations none done

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ injured at work? \_\_\_\_\_

23. SIGNATURE Alayson C. Webb MD

Jan. 21 - 46 M. D. or other \_\_\_\_\_

Address Chesapeake Md

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 26 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00869

Reg. Dist. No. 281

## 1. PLACE OF DEATH:

County St. Marys  
 City or town Rural Hermannville, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys  
 City or town Rural Hermannville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Maise Chase

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Black 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 29, 1922  
 8. AGE: Years 23 Months 7 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Prager Md  
(Town, county, and state)10. Usual occupation none

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name Albert Chase  
 13. Birthplace Maryland  
 14. Maiden name Agnis Matthaus  
 15. Birthplace Maryland

16. Informant Agnis Chase  
 Address Hermannville Md

17. Burial Date thereof Jan 8 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Peter's Cemetery  
 Location Ridge Md

18. Funeral director P.B. Robinson  
 Address Leonardtown Md

19. Jan 7 1946  
 (Date rec'd by registrar) H. Green Md  
Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1946 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Dec 1 1945  
 and that I last saw her alive on Dec 1 1945

Immediate cause of death \_\_\_\_\_

Carcinoma of intestine  
 Due to \_\_\_\_\_

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Including pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE H. Green Md M. D. or other

Address Great Mills, Md Date signed 1/7/46

STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

RECEIVED  
JAN 9 1946  
BUREAU V. E.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Diat. No. 282

## 1. PLACE OF DEATH:

County St Marys  
 City or town Leonardtown Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
2 1/2 months St Marys Hospital  
 How long in hospital or institution? 2 1/2 months St Marys Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys  
 City or town Leonardtown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles R. Clements

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 8.(b) Name of husband or wife Lillian Russell Clements  
 7. Birth date of deceased (mo., day, yr.) July 17 - 1890 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 55 Months 3 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Leonardtown St Marys Maryland  
 (Town, county, and state)10. Usual occupation Fireman Leonardtown, Md11. Industry or business Quaterman Labour, Md12. Name C. John Clements13. Birthplace St Marys Co14. Maiden name Rosa M. Dantse15. Birthplace St Marys Co16. Informant Mrs Agnes TurmanAddress Leonardtown Md17. (Burial, cremation, or removal. Which?) Burial Date thereof Jan 18 1946  
 (month) (day) (year)Cemetery or crematory St Albans CemeteryLocation Leonardtown Md18. Funeral director W C Mattingley SonsAddress Leonardtown Md19. 1/16 46 Clements  
 (Date rec'd by registrar) \_\_\_\_\_ Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 - 19 46 at 8:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 9 19 45 to Jan 15 19 46  
 and that I last saw him alive on Jan 14 19 46

Immediate cause of death Chronic Myocarditis  
 DURATION \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Fluency with Effusion

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Paul A. Cameron  
 M. D. or other \_\_\_\_\_Address Leonardtown Date signed 1/16/46

RECEIVED

U.S. DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF JUSTICE

RECEIVED

JAN 17 1946

BUREAU V.E.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 463

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH: St Marks  
 County Leonardtown md  
 City or town Leonardtown md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 days  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? 12 days

## 3. (a) FULL NAME

Eugene Howard Davis

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Bethanne Elsie Payne

7. Birth date of deceased (mo., day, yr.) March 13 - 1875

8. AGE: Years 70 Months 10 Days — If less than one day — hrs. — min. —

9. Birthplace Compton St Marks Md  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business —

12. Name Howard Davis

13. Birthplace St Marks Co

14. Maiden name Bessie E. Howard

15. Birthplace St Marks Co

16. Informant Howard E. Davis Jr

Address Compton Md

17. Burial Date thereof Jan 16 - 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Francis Xavier

Location Compton Md

18. Funeral director W. C. Mattingly Son

Address Leonardtown Md

19. Jan 15 1946 Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marks

City or town Compton  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. —  
 (If rural, give LOCATION)

2. (a) If veteran, name war —

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1946 at 3:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — to —

and that I last saw h. i. in alive on January 13 1946

Immediate cause of death Generalized Carcinomatosis

Due to Ca of Gallbladder

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations Generalized Carcinomatosis

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Robert V. Fuchs, M.D.

Address Leonardtown, Md Date signed 1/13/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 17 1946  
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 00872  
 282  
 ★ Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....*St. Mary's*  
 City or town.....*Lanville, md*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....*Life*  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*md* County.....*St. Mary's*  
 City or town.....*Lanville, md*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*Lucy Edwinna Graves*

## 3. (b) Social Security Number

4. Sex

*F.*

5. Color or race

*W.*

6.(a) Single, married, widowed, or divorced

*Widow*

6.(b) Name of husband or wife

*Charles H. Graves*

7. Birth date of

deceased (mo., day, yr.)

*April 27<sup>th</sup> 1867*

6.(c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

*78**9**7*

.....hrs. ....min.

9. Birthplace.....

*Compton, St. Mary's, md*  
(Town, county, and state)

10. Usual occupation.....

*Housewife*

11. Industry or business

FATHER

12. Name.....

*Stephen H. Bomles*

13. Birthplace.....

*md*

MOTHER

14. Maiden name.....

*Martha J. Mattingly*

15. Birthplace.....

*md*

16. Informant.....

*Lynch Wood*

Address.....

*Lanville, md.*

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

*1-7-46*  
(month) (day) (year)

Cemetery or crematory.....

*St. Joseph*

Location.....

*Lanville, md*

18. Funeral director.....

*H.C. Mattingly Sons*

Address.....

*Lanville, md*

19.

(Date rec'd by registrar)

*1-6**46**Calver*

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

*1-3-*

19.....

*46* at *11:35 P.M.*

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

*Wed 20<sup>th</sup> 1945* to *Jan 3<sup>rd</sup> 1946*  
 and that I last saw him.....alive on.....*Jan 3<sup>rd</sup> 1946*  
 Immediate cause of death.....*Central artery*  
 DURATION.....*3 hrs*

Due to.....

*Heart  
Arterio Sclerosis*

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

*H.F. Freeman*

M. D. or other

Address.....

*Lanville, md*Date signed *Jan 4-46*

RECEIVED  
JAN 8 1946  
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 960

## CERTIFICATE OF DEATH

Reg. Dist. No. 281

### 1. PLACE OF DEATH:

County St. Marys

City or town Leonardtown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

St. Marys Hospital

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town Rural, Dryden  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Mary Elizabeth Mason Green

### 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Black

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

George Jerome Green

7. Birth date of deceased (mo., day, yr.)

May 23 1904

6. (c) If alive, give age

44 years

8. AGE:

Years

Months

Days

If less than one day

41

7

11

hrs.

min.

9. Birthplace

Washington, D.C.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden name

Lottie Mason

15. Birthplace

Maryland

16. Informant

George Green

Address

Dryden Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 6, 46  
(month) (day) (year)

Cemetery or crematory

St. Georges

Location

Valley Lk. Md

18. Funeral director

P. B. Robinson

Address

Leonardtown

19.

1-3-46  
(Date rec'd by registrar)

P. B. Robinson  
Registrar

23. SIGNATURE

P. B. Robinson

M. D. or other

Address

Quist Mills Md

Date signed 1/7/46

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 19 46, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 3 19 46, to Jan 3 19 46

and that I last saw him alive on Jan 3 19 46

Immediate cause of death

Myocarditis

DURATION

3 months

Due to

Frequently repeated pneumonia  
(134)

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

UNITED STATES DEPARTMENT OF HEALTH

UNITED STATES DEPARTMENT OF HEALTH

RECEIVED

JAN 7 1946

BUREAU V S



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17020

## CERTIFICATE OF DEATH

Reg. Dist. No. 00874-282

### 1. PLACE OF DEATH:

County St. Marys  
City or town Leonardtown Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 hours  
Hospital, institution, or street address where death occurred:  
St. Marys Hospital  
How long in hospital or institution? 7 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys  
City or town MD  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Bernard Augustus Hall

### 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 17 1929 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years Months Days If less than one day  
16 9 27 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace General St. Marys Maryland  
(Town, county, and state)

10. Usual occupation School

11. Industry or business

12. Name Charles A. Hall

13. Birthplace St. Marys Co

14. Maiden name Annabel Harris

15. Birthplace St. Marys Co

16. Informant B. M. Hall

Address Wayley Md

17. Burial Date thereof Jan 17 1946  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Sacred Heart Cemetery

Location Sub. wood Md

18. Funeral director W. C. Matthews Son

Address Leonardtown Md

19. Jan 15 1946 Registrar Cummins  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 19 46, at 5:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I deceased on Jan 14 19 46

and that I last saw h. live on Jan 14 19 46

Immediate cause of death Internal hemorrhage DURATION

into left pleural cavity

Due to Wounded knee from

fractured ribs

Due to contusion of chest by

automobile

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of Jan 14 1946

Where did injury occur? Leonardtown Md  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury Automobile injured at work? No

23. SIGNATURE Francis F. Greenwell M. D. or other

Address Leonardtown Md Date signed Jan 15 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED TO THE SECRETARY OF THE ARMY

RECEIVED TO THE SECRETARY OF THE ARMY

RECEIVED  
JAN 17 1946  
BUREAU V A

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *21-0*

## CERTIFICATE OF DEATH

00875

Reg. Diat. No. *282*

## 1. PLACE OF DEATH:

County *St. Mary's*  
 City or town *Rural # 2 Leonardtown Md*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *2 1/2 years*  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *St. Mary's*  
 City or town *Rural # 2*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *Leonardtown Md.*  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

*John Francis Holly*  
 4. Sex *M* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *Widowed*

8. (b) Name of husband or wife *Anna Frost Holly*

7. Birth date of deceased (mo., day, yr.) *April 12 - 1876* 6. (c) If alive, give age *69* years

8. AGE: Years *69* Months *9* Days *5* If less than one day  
 .... hrs. .... min.

9. Birthplace *Clement St. Mary's Maryland*  
(Town, county, and state)10. Usual occupation *Farmer*

## 11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant *Louis Holly*Address *Leonardtown Md*

17. Burial, cremation, or removal, Which? *Burial* Date thereof *Jan 22, 1946*  
 (month) (day) (year)

Cemetery or crematory *St. Albans cemetery*Location *Leonardtown Md*18. Funeral director *W. C. Mattenley Son*Address *Leonardtown Md*

19. *Jan 21, 1946* Registrar  
 (Date rec'd by registrar)

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan 19* 19 *46*, at *3:35 p.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Jan 10* 19 *46*, to *Jan 19, 46*and that I last saw him alive on *Jan 19, 46*

Immediate cause of death

DURATION

Due to *Arterio sclerosis*

Due to

Other conditions *Chronic nephritis*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE *F. G. Camalini*

M. D. or other

Address *Leonardtown* Date signed *1/24/46*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

January 23, 1946

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

DECEASED

IN THE DISTRICT OF COLUMBIA

RECEIVED  
JAN 23 1946  
BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 162

## CERTIFICATE OF DEATH

Reg. Dist. No. 115787

### 1. PLACE OF DEATH:

County St. Marys

City or town St. Marys City  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town St. Marys City  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

### 3. (a) FULL NAME

Thomas R. Keister

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife .....

7. Birth date of deceased (mo., day, yr.) December 20, 1945 8.(c) If alive, give age ..... years

8. AGE: Years Months Days If less than one day  
15 hrs. min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation none

11. Industry or business .....

12. Name Ielon C. Keister

13. Birthplace West Virginia

14. Maiden name Nellie Shawen

15. Birthplace West Virginia

16. Informant Nellie Keister

Address St. Marys City

17. Burial Date thereof 1/5/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Poplar Hill

Location Valley Lee

18. Funeral director P.B. Robinson

Address Leonardtwn, Md.

19. 1/5-46 Registrar Caecilia  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1946 at 6:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h..... alive on ..... 19.....

Immediate cause of death Suffocation

DURATION

Due to Swen head cold and

Due to nasal hemorrhage

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. F. ... M. D. or other

Address Leonardtwn, Md. Date signed 1/4/46

MARGIN RESERVED FOR BINDING

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

00877

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town Heisterman  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 minHospital, institution, or street address where death occurred: St. Mary's HospHow long in hospital or institution? 10 min

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County St. Mary'sCity or town Valley Lee  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Infant Miller

## 3. (b) Social Security Number

## 4. Sex

m

## 5. Color or race

w

## 6. (a) Single, married, widowed, or divorced

—

## 6. (b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

Jan 24 / 46

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

hrs. 10 min.

## 9. Birthplace

Ind  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## FATHER

## 12. Name

Randall E. Miller

## 13. Birthplace

20. Va

## MOTHER

## 14. Maiden name

Jane Hewlings

## 15. Birthplace

va

## 16. Informant

## Address

Randall E. Miller  
Valley Lee, Ind

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

1 / 24 / 46  
(month) (day) (year)

## Cemetery or crematory

## Location

Home Premises  
Valley Lee, Ind

## 16. Funeral director

## Address

Randall E. Miller  
Valley Lee, Ind

## 19.

(Date rec'd by registrar)

19.

1 / 24 / 46Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Jan 24 46 at 4:25 P. M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 24 46 to Jan 24 46and that I last saw him alive on Jan 24 46

Immediate cause of death \_\_\_\_\_

## DURATION

Premature Birth

## Due to

Failure of mother's circulation

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work?

## 23. SIGNATURE

M. D. or other

Randall E. Miller  
Registrar Date signed 1 / 24 / 46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

15  
JAN 26 1946  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B.D.)

## CERTIFICATE OF DEATH

00878

Reg. Diat. No. 282

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town Scotland, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? life  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's  
 City or town Scotland, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James Charles James Norris

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Jan 5 - 1944 8. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years Months Days If less than one day  
2 - 10 \_\_\_\_\_ hrs. \_\_\_\_\_ min.8. Birthplace Scotland St. Mary's Md.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

FATHER 12. Name Lloyd E. Norris  
13. Birthplace St. Mary's CoMOTHER 14. Maiden name Ida M. Greenwell  
15. Birthplace St. Mary's Co16. Informant Albert E. Greenwell  
Address Scotland Md17. Burial Date thereof Jan 17, 1946  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Trinity  
Location St. Mary's City Md18. Funeral director W. C. Montgomery Sons  
Address Leonardtown Md.19. Jan 17, 46 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 19 46 at 1230 p.m.21. I CERTIFY that death occurred on the date above stated; that deceased deceased fromand that I last saw him dead on Jan 15 19 46Immediate cause of death Suffocation DURATIONDue to Asphyxiation on his neck by the tongue of a trailer coatDue to which while at play he hadlearned to fall on him

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, evicde, or homicide Accident Date of Jan 15 - 46Where did injury occur? Scotland St. Mary's Md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) on farm at homeMeans of injury piece of farm machinery injured at work? play23. SIGNATURE F. F. Greenwell M. D. or otherAddress Leonardtown Md. Date signed Jan 15 - 46

RECEIVED

JAN 18 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 00879

## 1. PLACE OF DEATH:

County St. Mary's  
 City or town US NAS, Patuxent River, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 19 days  
 Hospital, institution, or street address where death occurred:  
U. S. Naval Dispensary, Patuxent River, Md.  
 How long in hospital or institution? 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Calvert  
 City or town U. S. Naval Mine Warfare Test Station, Solomons Island, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

PLYLER, Charles Robert

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife --  
 8. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) 9 January 1946  
 8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace US NAS, Patuxent River, Maryland  
 (Town, county, and state)

18. Usual occupation newborn infant

## 11. Industry or business

12. Name Charles R. Plyler  
 13. Birthplace Cass, West Virginia  
 14. Maiden name Ethel Plyler  
 15. Birthplace Peterburgh, New Hampshire

16. Informant Father, Charles R. PlylerAddress USNMWTS, Solomons, Md.

Funeral home Date thereof 1-28-46  
 (Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory Sent to C. W. Jellison Fun HomeLocation Peterburgh, N. H.

## 18. Funeral director

Address Sanfordtown Rd.

1/28 1946  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1946 5:28 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 9 1946 to 27 January 1946

and that I last saw him alive on January 27 1946

Immediate cause of death Prematurity

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where)? \_\_\_\_\_

Means of Injury H. S. Wray Injured at work? \_\_\_\_\_23. SIGNATURE W. S. WRAY, Comdr. (MC) USN

M. D. or other

Address US NAS, Patuxent River, Md. Date signed 1-28-46

RECEIVED  
JAN 30 1946  
BUREAU V.E.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 516

## CERTIFICATE OF DEATH

Reg. Dist. No. 281

## 1. PLACE OF DEATH:

County St. Marys  
 City or town Rural California  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys  
 City or town Rural California  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Patuxent Road  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John Alvin Saylor

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mary L. Saylor  
 6. (c) If alive, give age 59 years  
 7. Birth date of deceased (mo., day, yr.) Jan 6, 1885  
 8. AGE: Years 61 Months 0 Days 13 If less than one day  
 hrs. min.

9. Birthplace York, Pennsylvania  
(Town, county, and state)10. Usual occupation Grand11. Industry or business Government12. Name William Saylor13. Birthplace Unknown14. Maiden name Hennette Shearer15. Birthplace Unknown16. Informant Mary L. SaylorAddress California Md17. Burial Date thereof Jan 21, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Baltimore, Md18. Funeral director James C. CowanAddress Hollins + Popoliton St Baltimore Md19. Jan 19, 1946 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19, 1946 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1, 1945, to Jan 19, 1946and that I last saw him alive on Jan 16, 1946

Immediate cause of death

Carcinoma of prostate

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alvin Saylor M. D. or otherAddress Great Mills Md Date signed 1/19/46

RECEIVED  
JAN 22 1946  
BUREAU